

114CSR14

**WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 14
UNFAIR TRADE PRACTICES**

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**SERIES 14
UNFAIR TRADE PRACTICES**

§114-14-1. General.

1.1. Scope.

a. The purpose of this ~~regulation~~ rule is to define certain practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and to establish certain minimum standards and methods of settlements of both first party and third party claims.

b. This ~~regulation~~ rule does not prohibit the use of additional methods above the minimum which are not in violation of this regulation or any other West Virginia statute or regulation.

c. ~~This regulation defines certain practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and establishes certain minimum standards for the settlement of claims.~~ This ~~regulation~~ rule applies to all persons and to all insurance policies and insurance contracts except Workers' Compensation Insurance.

d. This ~~regulation~~ rule is not exclusive, and other acts, not herein specified, may also constitute unfair claims settlement practices.

e. Nothing in this rule creates or recognizes, either explicitly or impliedly, any new or different cause of action not otherwise recognized by law.

1.2. Authority. -- W. Va. Code §§33-11-4a(h) and §33-2-10.

1.3. Filing Date. -- ~~April 3, 2003.~~

1.4. Effective Date. -- ~~April 3, 2003.~~

§114-14-2. Definitions.

For the purposes of this regulation, the following definitions shall apply:

2.1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

2.2. "Claimant" means either a first party claimant, a third party claimant, or both, ~~and~~

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~~includes such claimant's designated legal representative, a designated member of the claimant's immediate family, or any other person named by the insured who may legally act on his or her behalf and who so acts without compensation of any kind.~~

2.3. "First Party Claimant" or "Insured" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract for which premiums were paid by the claimant or on the claimant's behalf.

2.4. "Person" includes any individual, company, insurer, association, organization, society, reciprocal, business trust, corporation or any other legal entity, including agents, adjusters and brokers.

2.5. "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract covering risks resident, located or to be performed in this state.

2.6. "Investigation" means all activities of an insurer or agent directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

2.7. "Notification of Claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agents, by a claimant, which reasonably appraises the insurer or agent of the existence of an occurrence which might give rise to liability under a policy or contract of insurance.

2.8. "Third Party Claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer for which premiums were not paid by the claimant or on his or her behalf.

2.9. "Settlement of Claims" means all activities of the insurer or its agent which are related directly or indirectly to the determination of the extent of compensation that is due under coverage afforded by the insurance policy or insurance contract. This shall include, but not be limited to, the requiring or preparing of repair estimates.

2.10. "Insurance Policy" or "Insurance Contract" means the contract effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers issued under the terms of the policy or contract.

2.11. "Claim" means any communication by a claimant to an insurer or its agent which reasonably appraises the insurer or agent of an occurrence which might give rise to liability under

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a policy or contract of insurance.

2.12. "Commissioner" means the West Virginia Insurance Commissioner.

2.13. "Licensee" means any person that holds a license or Certificate of Authority from the commissioner, or any other entity for whom the commissioner's consent is required before transacting business in the State of West Virginia or with residents of West Virginia.

2.14. "Egregious Act" means conduct that is fraudulent or malicious and reckless, whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice. An act, or failure to act, that is due to negligence, lack of judgment, incompetence, or bureaucratic confusion, is not an egregious act.

§114-14-3. File And Record Documentation.

3.1. File and record documentation. -- The insurer's claim files shall be subject to examination by the commissioner or by his or her duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. All communications and transactions emanating from or received by the insurer shall be dated by the insurer. A notation of the substance and date of all oral communications shall be contained in the claim file. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.

§114-14-4. ~~Unfair Or Deceptive Acts Or Practices~~ Representation of Policy Provisions and Benefits.

4.1. Failure to disclose pertinent policy provisions. -- No person shall knowingly fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

4.2. Concealment of pertinent policy provisions. -- No person ~~shall~~ may knowingly conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

4.3. Coercive statements. -- No person ~~shall~~ may make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of the provisions of a statute of limitation or a policy or contract time limit.

4.4. Time limit for notification of claim. -- Except where a time limit is specified in the

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policy or set by statute or rule, no insurer may require a first party claimant to give notification of a claim or proof of claim within a specified time.

4.4: 4.5. Releases.

a. No person ~~shall~~ may request a first party claimant to sign a release ~~which that~~ extends beyond the subject matter which gave rise to the claim payment.

b. No insurer ~~shall~~ may issue any check or draft, in partial settlement of a loss or claim under a specific coverage, ~~which that~~ contains language which releases the insurer or its insured from its total liability.

§114-14-5. Standards For The Acknowledgment Of Pertinent Communications.

5.1. Acknowledgment of notices of claims. -- Every insurer, upon receiving notification of a claim shall, within fifteen (15) working days, acknowledge the receipt of such notice unless full payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

5.2. Answer of inquiries from Insurance ~~department~~ Commissioner. -- Every insurer, producer or other licensee, upon receipt of any inquiry other than a notice of third party administrative complaint from the Insurance Department respecting a claim Commissioner shall, within fifteen (15) working days of receipt of such inquiry the date appearing on the inquiry, furnish the ~~department~~ commissioner with a complete written response to the inquiry. A “complete written response” addresses all issues raised by the complainant or the commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the commissioner or his or her staff conducting a scheduled examination on the insurer’s premises.

5.3. Replies to other pertinent communications. -- A reply shall be made within fifteen (15) working days of receipt by the insurer to all other pertinent communications from a claimant which reasonably suggest that a response is expected.

5.4. Provisions of assistance to first party claimants. -- Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer’s reasonable requirements. Compliance with this ~~paragraph~~ subsection within fifteen (15) working days of notification of a claim shall constitute compliance with subsection 5.1 of this section.

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**§114-14-6. Standards For Prompt Investigations And Fair And Equitable Settlements
Applicable To All Insurers.**

6.1. Investigation of claims. -- Every insurer shall promptly conduct and diligently pursue a thorough, fair and objective investigation and may not unreasonably delay resolution by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute.

6.2. Establishment of investigatory procedures. --

(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within fifteen (15) working days of receipt of notice of claim.

(b) Every insurer shall provide to every first party claimant, or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of ~~the~~ such claimant, within fifteen (15) working days of receiving notice of the claim.

(c) A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent ~~notifies~~ promptly provides written notification to the person filing the claim that the agent is not authorized to receive notices of claim.

6.3. Duty after investigation. -- Within ten (10) working days of the completion of its investigation, the insurer shall deny the claim in writing or make a written offer, subject to policy limits.

~~6.2.~~ 6.4. Offers of settlement. --

(a) In any case where there is no dispute as to coverage ~~or~~ and liability, it shall be the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

(b) No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The commissioner shall consider any evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

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1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;
3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
4. The extent to which the insurer considered the opinions of independent experts;
5. The procedures used by the insurer in determining the dollar amount of property damage;
6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and
7. Any other credible evidence presented to the commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is or is not below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

~~6.3.~~ 6.5. Denial of claims. -- No insurer ~~shall~~ may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing or as otherwise provided in subsection ~~6.4~~ 6.6 of these rules.

~~6.4.~~ 6.6. Records of denial of claims. -- If a denial of a claim is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

~~6.5.~~ 6.7. Notice of necessary delay in investigating claims. -- If the insurer needs more ~~time than thirty (30) calendar days from the date that a proof of loss from a first party claimant or notice of claim from a third party claimant is received~~ to determine whether a ~~first party~~ claim should be accepted or denied, it shall so notify the ~~first party~~ claimant in writing within fifteen (15) working days after ~~receipt of the proofs of loss~~ the thirty-day period expires. If the investigation remains incomplete, the insurer shall ~~send to such claimant within thirty (30) calendar days from the date of the initial~~ provide written notification and of the delay to the claimant every thirty (30) forty-five (45) calendar days thereafter, a letter setting until the investigation is complete. All such notifications must set forth the reason(s) additional time is needed for investigation. Where there is a reasonable basis supported by specific information

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available for review by the commissioner that such claimant has fraudulently caused or contributed to the loss ~~by arson~~, the insurer is relieved from the requirements of this subsection: *Provided*, That the claimant shall be notified of the acceptance or denial of the claim within a reasonable time allowing for full investigation ~~after receipt by the insurer of a properly executed proof of loss~~. Nothing contained in this subsection shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

~~6-6:~~ 6.8. Liability of others. -- Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

~~6-7:~~ 6.9. Denial of claims for failure to exhibit property. -- No insurer ~~shall~~ may deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit said property.

~~6-8:~~ 6.10. Separation of claims. -- In any case where there is no dispute as to one (1) or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

~~6-9:~~ 6.11. Time for payment of claims. -- Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than fifteen (15) working days from the receipt of such agreement by the insurer or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

~~6-10:~~ 6.12. Notice of applicable time limitations. -- No person shall negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant's rights may be affected by a statute of limitations or a policy or contract time limit. Such notice shall be given to first party claimants not less than thirty (30) days, and to third party claimants not less than sixty (60) days, before the date on which such time limit may expire.

~~6-11:~~ 6.13. Avoidance of payment. -- Where liability and damages are reasonably clear, no person ~~shall~~ may recommend that third party claimants make claim under their own policies solely to avoid paying claims under an insurer's insurance policy or insurance contract.

~~6-12:~~ 6.14. Unreasonable travel. -- No person ~~shall~~ may require a claimant to travel unreasonably either to inspect a replacement motor vehicle or to obtain a repair estimate ~~or to have the motor vehicle repaired at a specific repair shop.~~

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6.15. Compensation based on claim denials. -- No insurer may offer incentives or compensate its employees, agents or contractors based on savings to the insurer as a result of improperly denying the payment of claims.

6.16. Claim proceeds used to pay premiums of another policy. -- No insurer may deduct from a claim payment made under one policy premiums owed by the insured on another policy unless the insured consents.

6.17. Truth detection devices. -- No insurer may request or require a claimant to submit to a polygraph examination or other truth detection device unless authorized under the applicable insurance contract and state law. No insurer may utilize a truth detection device in connection with the settlement of a claim unless the claimant gives written consent prior to the use of the device.

6.18. Required information for claim denial notices. -- Any notice rejecting any element of a claim shall contain the identity and the claims processing address of the insurer and the claim number. The notice must state that the claimant has the option of contacting the commissioner. The notice must provide the commissioner's mailing address, telephone number and web site address.

§114-14-7. Standards For Prompt, Fair And Equitable Settlements Applicable To Automobile Insurance.

7.1. Applicability. -- This section is applicable to claims arising under motor vehicle collision and comprehensive coverage. The provisions of section 6 of these rules shall continue to be applicable to these claims except to the extent that such provisions are inconsistent with the specific provisions of this section.

7.2. Definition of terms. -- The following shall govern the construction of the terms used in this section:

a. "Agreed price" shall mean the amount agreed to by the insurer and the insured, or their representatives, as to the reasonable cost to repair damages to the motor vehicle resulting from the loss, without considering any deductible or other deductions;

b. "Designated representative" shall mean a person designated by the insured to represent him or her in negotiations with the insurer in an attempt to settle the claim. Such designated representative may be a member of the insured's immediate family or any other person named by the insured who may legally act on his or her behalf and who so acts without compensation of any kind;

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c. “Motor vehicle” shall have the meaning ascribed in subsection (b), section one, article one, chapter seventeen-a of the Code of West Virginia of 1931, as amended;

d. “Official used car guide” means a valuation source that has been approved by the commissioner for setting the minimum value of a motor vehicle which is the subject of a total loss claim. In order to be approved by the commissioner as an official used car guide, the valuation source must meet the following criteria:

1. All valuation sources must:

A. Produce statistically valid fair market values based on current data available primarily from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters, such as time and area, to assure statistical validity;

B. Produce values for at least eighty-five percent (85%) of all makes and models of private passenger automobiles for the last fifteen (15) model years and include all major options. A sufficient number of vehicles shall be used for each year, make and model to represent a cross-section sufficient to determine fair market values;

C. Produce for examination by the commissioner, at the time the request for approval is made or as soon thereafter as practicable, the source of the data in a manner that can be verified by the commissioner;

D. Make available for examination by the commissioner, at the time the request for approval is made or as soon thereafter as practicable, any contracts or agreements between the valuation source and insurers, which the valuation source may assert is a trade secret pursuant to W. Va. Code §47-22-1(d); and

E. Produce for examination any other information determined by the commissioner to be helpful or necessary in determining the statistical validity of the values produced by the valuation source, or otherwise bearing on the integrity of the valuation source, including the existence of and resolution of consumer complaints based upon total loss valuations performed by the source. If the information meets the definition of trade secret pursuant to W. Va. Code §47-22-1(d), then the valuation source may make available for examination by the commissioner, without filing the same, any information requested pursuant to this subparagraph. If the information meets the definition of trade secret pursuant to W. Va. Code §47-22-1(d) and, after having been made available for examination by the commissioner, the commissioner determines that the information pertains to the existence of or resolution of consumer complaints, the valuation source shall propose a reasonable method for protection of the information.

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2. A valuation source that is other than a valuation manual, including a computerized database, must meet the criteria set forth in subparagraphs A, B, C, D and E of paragraph one of this subdivision, and in addition must:

A. Give primary consideration to the values of vehicles in the local market area but if necessary to obtain a reasonable cross-section of the market, may consider vehicles in the next closest area;

B. Rely upon values of vehicles that are currently available or were available within ninety days from the date of loss for all vehicles and apply appropriate standards of comparability;

C. Rely upon values derived primarily from verifiable data or inventory from licensed dealers which have minimum sales of one hundred motor vehicles per year in the local market area, for vehicles of five model years or less of age;

D. Monitor the average retail price of private passenger automobiles when there is insufficient data or inventory from licensed dealers to ensure statistically valid market area values; and

E. Clearly indicate and describe the condition at which the vehicle is being valued, if the valuation source uses several price ranges for the same model vehicle depending on the condition of the vehicle. Documentation of the condition of the insured vehicle must be made a part of the written valuation. Deductions made for the condition of the insured vehicle must be reasonably based on a physical attribute that has the effect of decreasing the vehicle's value.

e. "Substantially similar vehicle" shall mean a motor vehicle of the same make, model, year and substantially the same condition, including all major options of the insured vehicle. Mileage must not exceed that of the insured vehicle by more than 4,000 miles unless mutually acceptable to both the insurer and the insured.

7.3. Adjustment of partial losses. -- The following subdivisions shall govern the conduct of insurers in the adjustment of partial losses:

a. Insurers shall include the insured's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense;

b. If an insurer prepares an estimate of the cost of the motor vehicle repairs, such

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estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the insured and may furnish to the insured the names of one or more conveniently located repair shops that will perform the repairs for the amount tendered in settlement of the claim;

c. If the insurer intends to exercise its rights to inspect damages prior to repair, it shall have seven (7) working days from the date of receipt of notice of loss to inspect the insured's damaged motor vehicle at a place and time reasonably convenient to the insured. In addition, negotiations shall commence and a good faith offer of settlement shall be made within the aforesaid seven (7) day period;

d. If the insured's motor vehicle is repaired at a repair shop of the insurer's choice, for a sum estimated by the insurer as the reasonable cost to repair the vehicle, the insurer shall, at no additional cost to the claimant and within a reasonable period of time, cause the damaged vehicle to be restored to the condition it was in prior to the loss if the repair shop it recommended does not so repair the damaged motor vehicle;

e. Deductions for betterment and/or depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and/or depreciation shall be limited to an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part. Calculations for betterment, depreciation and normal useful life must be included in the insurer's claim file;

f. Deductions for previous damage or prior condition of the motor vehicle must be measurable, discernible, itemized and specified as to dollar amount, and such deductions must be detailed in the claim file;

g. The insurer must mail or hand deliver to the insured or his or her designated representative its proof of loss or payment within ten (10) working days after the insured has accepted the insurer's offer;

h. If the insurer does not perform its own physical inspection, it is nevertheless bound by all the applicable requirements of this regulation.

7.4. Adjustment of total losses. -- The following subdivisions shall govern the conduct of insurers in the adjustment of total losses:

a. If the insurer elects to make a cash settlement:

1. It must use the most recent version of an "Official Used Car Guide"

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approved by the commissioner and uniformly and regularly used by the company, as a guide for setting the minimum value of the motor vehicle which is the subject of the claim. Any deviation downward from the guide's retail valuation must be supported by documentation that gives detailed information about the vehicle's condition, and any deductions must be measurable, discernible, itemized and specified concerning dollar amount, and they shall be appropriate in amount. This documentation must be maintained in the claim file;

2. If the retail value of the specific motor vehicle is not contained in the most recent version of an "Official Used Car Guide" approved by the commissioner and which is used uniformly and regularly by the company, the company must secure dealer quotations on the retail value of similar vehicles and base the settlement upon them. The offer must enable the insured to purchase the substantially similar vehicle for the cash settlement and any deviation from this practice must be supported by documentation giving particular information about the motor vehicle's condition. The documentation and the source of the dealer quotations must be maintained in the claim file;

3. The company shall provide a reasonable written explanation to the concerned parties when cash settlement offers, as set forth in paragraphs (1) and (2) above are made. The explanation must specify the dollar amount of the base figure and identify the actual source. Any additions or subtractions from the base dollar figure must be identified and explained; and

4. In addition to any cash settlement value agreed to by the claimant, there must be added an amount equal to five percent (5%) of such cash settlement value, as reimbursement to the claimant for the excise tax imposed by the state.

b. If the insurer elects to replace the vehicle, the replacement vehicle must be an immediately available, substantially similar vehicle that is both furnished and paid for by the insurer, subject to the deductible, if any.

c. If the insured vehicle is a private passenger automobile of the current model year, meaning that it has not been superseded in the marketplace by an officially introduced succeeding model, the insurer shall utilize one of the following methods in the settlement of the loss, except where the method used would be detrimental to the interests of the insured as compared with utilization of the methods described in subdivisions a and b above:

1. The insurer shall pay to the insured the reasonable purchase price on the date of loss of a substantially similar vehicle, less any applicable deductible and an allowance for depreciation in accordance with an official used car guide which has been approved by the commissioner and is used regularly by the insurer; or

2. The insurer shall furnish the insured with a substantially similar

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replacement vehicle, and charge the insured for any applicable deductible and for depreciation in accordance with the official used car guide.

d. If the insurer, in the process of adjusting a total loss, makes a deduction for the salvage value of the insured vehicle, the insurer must furnish the insured with the name and address of a salvage dealer who will purchase the salvage for the amount deducted.

e. All applicable provisions of subsection 7.3 of this section “Adjustment of Partial Losses” also shall apply to the adjustment of total losses, except that the insurer shall be allowed an additional five (5) working days to comply with the requirements set out in subsection 7.3 of these rules. Any letter of explanation or rejection of any element of a claim shall contain the identity and claims processing address of the insurer, the insured’s policy number and the claim number.

7.5. Unreasonable delay. -- If any element of a physical damage claim remains unresolved more than fifteen (15) working days from the date of receipt of proofs of loss by the insurer, the insurer shall provide the insured with a written explanation of the specific reasons for the delay in the claim settlement unless reasonable grounds exist to suspect fraud or arson. An updated letter of explanation shall be sent every thirty (30) calendar days thereafter until all elements of the claim are either honored or rejected.

7.6. Repair estimates. -- If an insurer requires that its insured obtain an estimate or estimates of vehicle damage, the reasonable charges, if any, of such estimates shall be borne by the insurer.

7.7. Notice of right to reimbursement for transportation expenses. -- In the event of the theft of the entire vehicle, it shall be the duty of the insurer at the time of notification of loss to advise the insured of his right under the policy to be reimbursed for transportation expenses. Such notification must be confirmed in writing immediately after receipt of notice of theft. All conditions and benefits related to this coverage as stated in the policy must be contained in the notification to the insured.

§114-14-8. Training and Certification.

8.1. Communication of investigatory and claim processing standards. -- Within ninety (90) days of the effective date of this rule, every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims.

§114-14-8. §114-14-9. Separability.

~~8.1.~~ 9.1. Partial invalidity. -- If any provision of this ~~regulation~~ rule shall be held invalid,

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the remainder of the ~~regulation~~ rule shall not be affected thereby.

~~§114-14-9.~~ §114-14-10. Penalty For Violation Of Any Provision Of This Regulation.

~~9.1.~~ 10.1. Penalty. -- Any person who fails to comply with any provision of this regulation shall, after notice and hearing, be found to be transacting insurance in an illegal, improper or unjust manner. The commissioner may, pursuant to ~~section eleven, article three, chapter thirty three, sections six, seven and eight, article eleven, chapter thirty three and section twenty five, article twelve, chapter thirty three of the Code of West Virginia of 1931, as amended,~~ W. Va. Code §§33-3-11, 33-11-6, 33-11-7, 33-11-8 and 33-12-25, refuse to renew, or may revoke or suspend the license of any such person or, in lieu thereof, the commissioner may, at his discretion, order such person to pay to the state of West Virginia a penalty in a sum not to exceed that imposed by said sections of said code, and the commissioner may, pursuant to ~~section eleven, article two, chapter thirty three of said code~~ W. Va. Code §33-2-11, order such person to discontinue such illegal, improper or unjust transaction of insurance and to adjust and pay obligations as they become due.